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MENTAL HEALTH

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Editorial

Criminal Responsibility

Relations between representatives of the legal profession and psychiatrists cannot be regarded with much satisfaction by either side—except in so far as satisfaction can be obtained by acid criticism of the other. The fundamental difficulties, though clear, are not always evident to the man in the street and are particularly easy to neglect when involved in the highly sensational atmosphere of a murder trial; this is of course particularly so if the details are horrific or sexual or both and if a plea of insanity is raised in defence. It may therefore be helpful to re-state the points at issue.

The first point is that lawyers and doctors talk in different terms. This is not quite so simple as to say, in the words of a judge, that one language is forensic and one scientific, for the confusion is made worse confounded by the fact that certain terms are used by the two professions in different senses. Further, it is very easy for discussion to get bogged down in terminological misconception: readers of the Heath trial—just published in the Notable British Trial Series (William Hodges, Glasgow, 1953)—will notice the confusion of "moral defect" and "moral insanity".

The second point is that the methods of law and medicine in arriving at the facts of a case are very different. The law holds that the truth will best come to light by allowing opposing counsel to bring forward opposing views, in black or white. To the doctor much is grey, and this is especially so for the psychiatrist who realises that if he is to get a full account of the patient's conduct and motives, he must show the greatest sympathy and tolerance. Because of this and because of the deeper understanding he may thus obtain, he is likely to be (as well as to seem) more sympathetic, either in his consulting room or in court.

It is therefore easy to see how clashes occur: and one can sympathise with the psychiatrist doing his best to present a complicated case in non-technical terms to an audience whose knowledge is little and who have quite possibly a prejudice against psychiatry. Dr. Yellowlees' outspoken and humorous reference to psychiatric evidence is noted on another page.

Though our readers are possibly more medical than legal in their outlook, they must feel sympathy for the counsel, saddled with what must be a distasteful job of trying to discredit the evidence or personality of a professional man even if (of course) he is adept at completely concealing his distaste.

Nevertheless whatever our sympathies, these clashes do little good to either side and leave a feeling of disquiet in the minds of the lay public and possibly of juries. There have already been attempts to revise the McNaughten rules, the most significant being Lord

Justice Atkins' committee in 1922 when the doctrine of irresistible impulse was supported. But this recommendation led to no change in the law, and changes in the law here will finally depend on changes in public opinion and, for lack of these, have failed in the past. But it is possible, after several recent sensational trials and their emotional aftermath, that public opinion is now ripe for such a change.

But though public opinion may sanction a change it cannot be expected to think clearly enough to propose better rules, and this must be the joint responsibility of the law and medicine. Surely we are now due for other attempts by the representatives of both sides, to meet and to collaborate?

Some Psychological and Spiritual Aspects of Acute Anterior Poliomyelitis

By PASTOR IGNOTUS

Special circumstances in the past two years have brought the writer (an ordinary parish priest of the Established Church) into close contact with a number of cases of "polio". A very extensive study of one of these, supplemented by the observation of a relatively large number of others, suggests that the disease offers special opportunities for those who are interested in the "frontier" between the medical and theological sciences, and that his observations, even though still in a very tentative stage, may be of some interest.

A Case Study

A boy of 13½ succumbed to an attack of this disease (third in a family of five). He was physically a first class specimen, energetic and athletic, but he was notably inverted in type and preferred to take his exercise in company with his chosen friends, feeling little response to community pressures, organised games and school loyalties. He had a marked tendency to avoid responsibility and his picture of the future unashamedly sought a life in which difficulties and discomforts were avoided rather than faced and overcome. It is worth noting that his school report for the preceding term had been a great disappointment, after a good grammar school entry at the usual II plus examination. There is no doubt that he had shown throughout his life an abnormally low "threshold" to pain and perhaps to fear.

When he first began to feel the effects of the virus in his system he said nothing about it as he was due to go on a long bicycle ride with a friend. The consequences were, not unnaturally, disastrous. He became critically ill and in 24 hours was transferred

to hospital. The paralysis rapidly spread, affecting the back, limbs and respiratory muscles. He was placed in an iron lung and remained for a fortnight in a state of high fever during which recovery seemed most unlikely. Of this period he now has little or no recollection.

The writer came into the picture about a month after the onset of the disease. By that time the boy's body showed considerable wastage. The four occasions a day on which he was removed from the lung for "servicing" were ordeals for patient and nursing staff alike. His emaciated state, coupled with extreme muscular tenderness and his slender hold on life cut down the possible time for massage of pressure points with consequent development of severe bedsores which in their turn contributed to the now established cycle of fear, inescapable pain, emotional outbursts and subsequent exhaustion. It seemed impossible in the circumstances to stimulate appetite and every meal became a battlefield. The doctor in charge of the case felt that if the cycle could not be broken, the prognosis was highly unfavourable.

The writer does not pretend to have sized up the situation from the outset but one thing was apparent on the first occasion when he was allowed to be present at one of these "servicing" sessions. The boy behaved like an animal caught in a trap and was impervious to the suggestions of the staff. There was clearly a severe failure in confidence due to the constantly reiterated association of nurse with pain. It was equally clear that a continuance of this situation represented a danger to both reason and life. It seemed essential therefore to re-establish in the patient *some* confidence in his environment.

The Priest and the Patient

Without in any way prejudging the "religious question" it is obvious that a parish priest is better equipped for such a task than most people. He comes as the representative of an objective reality which is in every sense above and beyond the battle. This patient, though far from being a "religious" boy, had received some previous instruction and to this he probably owes his life. The combination of a cassock and a dog-collar with such instruction is enough to create an immediate relationship and the teaching already given establishes a potential area of shared concern.

In the course of conversation and reading aloud, courage and the reality of the Love of God, were the main themes held out. The patient proved very responsive. He attempted to carry out suggestions with a pathetic eagerness though at first with little success. To some extent, this was helped by an early release from pain which accompanied the laying on of hands and a short prayer. The probable explanation of this is not markedly supernatural. Muscular spasm comes through fear and in an atmosphere of trust

there was consequent relaxation. Confidence once gained was complete and although there were ups and downs for the first three months, we now seem well set towards a recovery of the respiratory muscles though the prognosis for the remainder of the paralysis cannot yet be assessed.

It is important to note that both the child's parents were visiting him twice daily in the early stages of his illness and then once daily but were unable significantly to influence the course of events.

Nurse-Patient Relationships

A number of fluctuations in the recovery rate of the patient could be traced to nursing factors. The conventional pattern of the nursing hierarchy with its rigid chain of command—doctor, sister, staff nurse, nurse, patient—with the patient's personal reactions very much at the bottom in order of importance, seems more than usually unsuitable in these cases. It appears to the writer that more instruction on their psychological problems and the way to meet them is drastically necessary and that the proper approach ought to be part of the curriculum in the training of sister-tutors. Here is an example of an apparently minor but important aspect of the nurse-patient relationship. The patient in an iron lung is helpless. He is a *patient* in the exact sense of the term; everything happens *to* him. He can initiate nothing. He can only speak as a machine gives him breath. In these circumstances quite small whims—the alteration of an accepted order of procedure, the delay of a minute or two in beginning it—assume tremendous importance. They are tokens that he is not the complete slave of his environment, and guardians of a continuing personality that daily receives severe disintegrating shocks. They ought where possible (i.e. usually!) to be acceded to even though this appears to "spoil" the patient—a situation of which sisters and nurses appear to have an exaggerated fear. From the religious point of view it means substituting Love for Routine, as the only response adequate to the patient's desperate situation.

Looking Forward

In every severe case of polio, a point is reached when the battle of the febrile stage behind him, the full weight of a possibly totally disabled future breaks in a cloud of anguish upon the patient's consciousness. The hospital chaplain is then an essential part of therapy, and he needs a firm grasp of the elements of his own science if he is to discharge his duty. A general benevolence and desire to help will not suffice. It is part of his duty to ensure that all concerned—doctors, nurses and patient—have their whole attitude orientated towards a recovery as complete as possible. The balance between victory and defeat, even in the movement of a limb, is a delicate one, and the factors which affect it are as yet far

from fully understood. The dictum that destroyed nerve tissue never recovers, may be a valid scientific generalisation but it has an unfortunate subconscious effect on the approach to paralysis. During acute phases of the disease the pressure on the patient to abandon the struggle as increasing helplessness is forced upon him, is very heavy. It must never receive reinforcement from without.

The tenor of these notes has been to suggest that the priest has a proper part to play in the treatment of poliomyelitis—a part which is both significant and not lightly to be dispensed with. No reference has here been made to the great enrichment of the writer's spiritual knowledge and experience which has come to him from the cases described above—which though his special concern, is not, perhaps, of general interest. He desires to record his appreciation of the co-operation he was permitted to exercise with a devoted medical and nursing staff, but at the same time it must also be recorded that his special contribution is as yet far from completely accepted; indeed at one stage or another it usually provokes some resistance.

Adoption

A Study of the Problems involved in Child Guidance Cases, from the View-point of a Psychiatric Social Worker

By PENELOPE PHIPPS, B.Sc. (H & SS)
P.S.W. Maidstone Child Guidance Clinic

"It is not as if he was of us", said the adoptive mother. "One can understand one's own flesh and blood".

What were the fears, disappointments and misunderstandings that underlay that remark?

My work as a Psychiatric Social Worker involves interviewing parents of children attending the clinic and, during the last three years, remarks, such as that quoted, drew my attention to the special problems that adoptive parents have to face. This study has been made in order that future cases may be the more ably treated. It is restricted to adoptive as distinct from foster-parents in order to limit the field of study to cases in which there is no conscious fear that the child may be removed. The adoptive parents are referred to throughout as the mother and father and the prefix "real" is used to denote the natural mother and putative father.

A survey of cases of adoption, seen between September 1949 and September 1952, showing numbers, ages, symptoms, diagnosis and clinic action and results is given in the Appendix.

Referral

Most of the parents had sought help when their anxiety could no longer be contained within the bounds of the family. They

had consulted their General Practitioner or told the School Medical Officer. Several of these cases would not have reached us if it had not been for the skill of the doctors in assessing that Child Guidance was necessary. The parents had not realised that such help was required. Precipitating causes for referral were : that the problem had spread from the home to the school or that anti-social symptoms had appeared in addition to others. The onset of adolescence with its accompanying problems was a further cause of referral and advice alone was required concerning one Educationally sub-normal child.

Other parents sought help only on finally rejecting their child. It seemed that a rejection climax had been reached, as though until that moment the mother had continued to hope, in the face of continued evidence to the contrary, that the child would fulfill her expectations. In one case, failure to pass the Grammar-school examination, had been the culminating factor causing rejection.

Reasons for Adoption

Mothers willingly gave their conscious reasons for adopting a child. Most had wanted a child of their own but could not have one because of sterility, repeated miscarriages or hysterectomy. A few mothers wished to replace a child of their own who had died. Some had taken pity on a homeless child and yet others had felt responsibility as relatives of children who had become homeless. There were mothers who wanted more children than they had been able to bear or wanted another young baby when their own children were growing up. One had refused to risk having a child during the war and afterwards felt too old.

After the mothers had attended the clinic for some time their underlying reasons for adopting a child became apparent. These reasons were often identical with those of mothers wanting to bear their own child.

Some needed a child on whom to bestow love. This is a normal sign of motherliness unless the love be excessive. In cases where the love was excessive it was found that the mothers were trying to give the child what they felt they had missed in their own childhood.

Yet others needed to prove themselves capable of mothering a child although incapable of making one : these were the inadequate or immature women.

Some mothers wanted to adopt a child as a protest at being unable to have a child after hysterectomy. Though this angle was not studied at the time, the question arises, had hysterectomy meant to them castration, mutilation or injury by the male?

There were the mothers who wanted their children to fulfill their own unsatisfied ambitions. He must be clever and successful or she, pretty and admired. This attitude is best described by

Deutsch when she says, "The mother is determined by her narcissistic wish to continue in him her own physical ego".

Personalities of Mothers

Reviewing the personalities of the mothers, I found that they numbered among them Obsessional, Anxious, Schizoid, Paranoid, Over-emotional, Immature, Egocentric, Hysteric and Agitated Depression. No correlation was apparent between the personality of the mother and the personality or problem of the child.

The quality of motherliness with tenderness as its chief characteristic was apparent in only one of the mothers. Deutsch states that women who have not received maternal love in their childhood develop less motherliness than others and this we found to be true in several cases. Deutsch considers, "The adoptive mother can be the full equivalent of the real mother to the child if he is assured a sufficient amount of biologically determined gratifications and an adequate emotional atmosphere".

Problems Arising from the Attitudes of the Parents

The underlying reasons for adoption and the attitude of the parents towards it are undoubtedly the cause of the majority of problems. The survey showed them to be a significant factor in many cases.

One of the principal attitudes causing problems arises from the need to be loved. In those instances in which the mother wanted to receive from the child the love which she had missed herself in youth, she demanded behaviour of a constantly gratifying nature. A mother of this type said that she used to cry over the child thinking, "Poor little mite, what might have happened to him if it had not been for me?" She was seeking to gratify herself by her own goodness. She was identifying the unloved child she had once felt herself to be, with the child she had adopted. This mother interpreted as rejection, normal expressions of aggression and felt, "This is what I get in return for my goodness" and wondered if she would have done better not to have adopted him. Others said they had lain for hours on the bed beside their child trying to win some expression of love. They failed, and then rejected the child and had no good to say of him. "No such debt (of gratitude)" says Deutsch, "exists in a really motherly relationship of a mother to her beloved child".

In those instances where the relationship between the parents was unsatisfactory and the mother was not receiving all the affection she required from the father, she sought an outlet through the medium of the child on whom was centred too great a force of emotion.

A further attitude of mind giving rise to problems was the need to love. Where the mother wanted to give the child all she

felt she had missed herself, there was a feeling of excess compassion for the helpless, homeless child she had befriended. The child was smothered with attention and gifts and was always allowed to have his own way. This hindered the development of the child's personality; there were reactions of aggressive behaviour or of over-dependence and lack of initiative. The mother was at a loss to understand why her child was more of a problem than children who received less attention. She was hurt at feeling her love rejected and felt aggressive towards the child. Hutchinson states, ". . . that the incentive (to adopt) is often a conscious or unconscious request for love is not so important as the character of this love, its reasonableness and normality, or its too unrelenting terms".

Another attitude of mind to cause difficulty was found in mothers needing to prove themselves capable of being good mothers. Some of this type were immature and hardly old enough emotionally to be mothers. Others were inadequate and, feeling keenly their inability to produce a child of their own, doubted their capacity to bring one up. Their handling of the children was over-anxious and restrictive and their anxiety was communicated to the children who tended to interpret restriction as punishment.

Those mothers who suffered from a sense of guilt were in many ways the most difficult. They blamed themselves for their sterility or for the ambivalent feelings they had towards the child. They expressed this at interviews by such remarks as "I feel extra responsible for him, more so than if he were my own child", or, "I feel guilty when I am annoyed with her because she gave me so much joy when I first had her". One mother felt that this sense of extra responsibility could best be assuaged by generous material provision for the child. She accordingly went out to work, thus neglecting the emotional side of the three-year-old's development. The guilty parents were the most averse to child guidance and occasionally withdrew from it, feeling that they could not expose their fault to outsiders. The burden of their guilt made them over-protective or over-permissive and prevented an easy mother child relationship.

Now and then, one encounters parents whose minds are set upon the fulfilment by the adopted child of his or her own unsatisfied ambitions. The mature mother loving a child, as a child, for itself, does not often need to find her way to this clinic. Those who wanted a child to conform to a pattern were building up a fantasy child in their minds. They did not see the child as he really was and were distressed when he did not fulfill their hopes and ambitions. When adopting a child the parents can state their requirements of age, sex and colouring. These may not be met, but, as Hutchinson tells us, it is not the motherly woman who makes rigid demands in the first place, but the more narcisstic woman who has preconceived ideas of what she wants. When too

rigid demands are made, she says, it is questionable if the foster parents really want a child. The children of such parents were found to be anxious and insecure, sensing rightly that they were not loved for themselves.

I came across one case of a mother who had, in her mind, identified the personality of the adopted child with that of her own child, lost by miscarriage in the later stages of pregnancy. This woman went so far as to speak to her husband of, "When I was carrying A . . ." and stopped short on remembering that it was a different child. She began to see in her adopted daughter the faults she had disliked in her own mother. Deutsch points out the dangers of interrupting mourning by adopting too soon after the death of a child, lest the mother should feel for the adopted child, "Why was it not you who died?"

Heredity

There are two aspects of the problem of heredity. On the one hand the heredity is known, as in an Educationally Sub-Normal child. On the other hand the hereditary factor is merely the parents fear that undue interest in sex matters arose from the child being illegitimate. The mothers who felt their child was a problem or had "let them down" had a ready made answer when they asked themselves "Whose fault is it?" The reply often was, "He inherits these failings. We don't know what may have been born in him". These mothers argued to themselves that the situation could not be through any fault of their own, that the child of a woman who had borne him illegally or the child whose parents had abandoned him, must surely inherit the badness of his real parents. One such mother could find no good in her child after she had been told that she was the product of an incestuous relationship. Another mother expressed her fear by saying, "If I had known who his real parents were, I might have been choosy and not had him". Behaviour which some mothers could accept from their own child was inexcusable from the stranger within the gate.

The guilty mother, anxious to prove that it is not her fault, lays the blame for the problem on the real parents. Deutsch sums up the problem when she says, "The child's normal conflicts of liberation, accompanied by hostility towards the parents, are interpreted as a sign that he does not "belong". She (the mother) does not realise that it is only her fantasy that leads her to interpret the child's behaviour . . . as a manifestation of bad heredity".

Rôle of the Real Parents

The real parents are thus given the rôle of the bad parents. They may also be a source of jealousy to the sterile mother who wants to be everything to her child but cannot make him. They are a real as well as a fantasied threat for, despite the legal adoption,

there is the underlying fear that the real mother might come first in her child's regard. "He might want to leave me when he is older. He might want to find his real parents", is frequently said. This fear has a basis in reality, for, unless the child has been loved selflessly he tends to be paranoid—suspicious of his parents—and may turn in his mind to the unknown real parents who might love him as he wants to be loved.

Telling the Child He Is Adopted

How then, and when, should a child be told he is adopted? Why did some of the parents feel that this was a thing their child must never know while others could tell him easily and naturally? It was often the mothers who feared the real parents who experienced difficulty in telling their child of his adoption. They feared they might be rejected in favour of the real parents. Linked with this was a feeling of guilt that they had not been able to produce their own child and a desire to pretend, at all costs, that they had. As Deutsch says, such mothers want to deny the facts and preserve the illusion. One mother said, "Supposing I told him to do something and he turned round and said, 'You're not my real mother'. It would break my heart". And she remained adamant that he must never be told. Another mother, fearing rejection but seeking to gather courage to tell her child, remarked, "Well, if I did tell him he shouldn't go against me; I've never been unkind to him".

The problems and attitudes of the parents are clearly revealed by the manner they employ and by the time chosen to tell the child he is adopted. The parents could exercise some choice when they took the child and, when they tell him he is adopted he may exercise a choice in whom he prefers. What a difference in attitude there was between the motherly woman who told her child, she had chosen him because she loved and wanted him, and those others whose need to be loved and appreciated was so great that they told their children that their real mothers had not wanted them and that was why they had taken pity on them.

Bowlby considers, "Provided adoptive parents can themselves admit the truth and do not have to cling, for personal reasons, to the fantasy of having produced the child themselves, there need be no great difficulty in bringing the child up from earliest years in the knowledge that he has been adopted. Complications will only arise if the natural and adoptive parents know each other".

Factors Influencing Adoption

Age

Of the factors influencing adoption, the age at which it takes place is the most widely discussed. The younger a child is adopted the more easily are most mothers able to feel that the child is theirs.

The fear that the child may have undergone experiences which will have a permanent adverse affect on his personality is obviated. Bowlby discusses problems raised by age at adoption and says, "On psychiatric and social grounds, adoption in the first two months should become the rule, though some flexibility will always be necessary . . . " Children seen here, who had been adopted at an older age by friends or relatives, seemed to have adjusted fairly well. The fact that the real parents and the child's early history were known and that there was a sense that the child belonged to the family or social group, seemed to render the problems of adoption at a later age, less acute.

Siblings

A large proportion of the parents seen here had adopted only one child. This study does not supply an answer to the questions which arise from this fact. One asks oneself, had one child been enough to satisfy the desire of the parents for children or were their inadequacies such that they could not take on more responsibility? It would also be interesting to know what is the proportion of "only children" amongst non-clinic adoptive families. Comparing children in adoptive families with children in non-adoptive families where, in every case, there was a mother and father figure and the children had been limited to one by intent, the common features that emerged were that the parents were either immature or self centred. Parents in the one category doubted their ability to look after more than one child and in the other were critical and rejecting of the one they had. If a mother felt more warmly to children born to her than to her adopted child jealousy ensued, no matter how hard the mother tried not to show her preference. A child of the mother, though adult, could also be jealous of the adopted child, feeling that the mother's own children should have sufficed her.

Parents

Most of the children had been adopted into families where there was a mother and father. In a few cases a single woman who was a friend or relative of the real parents had adopted a child. To be wage-earner and only parent was a strain on the mother. The effect on the child of the lack of a male figure depended largely on the mother's attitude to men; that is to say whether she pitied herself for not having a man, accepted it, or affected to scorn them. So far as is known none of the parents had themselves been adopted.

The majority of the fathers seen at the clinic were quiet unassuming men, as were some of the others by report. Hutchinson finds that foster fathers are frequently quiet and retiring, whilst foster mothers are more dominant personalities. It should be noted

that Hutchinson uses the term "foster parent" to include parents who adopt and those who board a child.

Intelligence

The intelligence of the children, was, in the majority of cases fairly well suited to the homes they were in. More anxiety about the intelligence was apparent amongst the socially 'better to do' families, even where the child adopted was that of a relative or friend. In several such cases the child adopted seemed very dull to the brighter parents though in fact he was average. In the instance of a very backward child being adopted, the parents came to us only for confirmation of diagnosis and accepted the findings without resentment saying that it might have been the same had they had one of their own.

Sex

Hutchinson states that "The wish for a child so often reflects the desire to love or be loved. Frequently children are to the foster parents the emblems of love. Especially is this true of little girls and this is one explanation of the inordinate demand for them by adoptive parents". This raises many interesting questions which this study does not solve. Is the demand for girls in this country as great as Hutchinson found it to be in the States? Do more women want a girl born to them than a boy? What proportion of women would want a girl if they knew they could only have one child? If the answer to these questions was available, and Hutchinson's finding accepted that it is usually the mother who takes the initiative in asking to adopt a child, the high demand to adopt girls might be found to be in line with the general preference of women to have daughters.

The request for a girl might mean that a woman sought to deny that her feminine role was inferior, or she might hope to win her husband's affection with the gift of a daughter. On a more conscious level a woman will say that a girl would be company in old age. Mothers feel that when a daughter marries they gain a son whereas when a son marries they will lose him to his wife.

So far as the expectation of affection from either sex may go, some parents state with conviction that girls are so much more affectionate than boys. Others state equally firmly that boys are so much more loving than girls.

Comparison with Foster Homes

Why should some parents wish to adopt and some to foster a child? Hutchinson tells us that "The adoptive applicant is not essentially different from the person who wishes to board a child, in fact the latter may have the same hope of permanency, but may seek through the boarding experience first to test out herself and

the child. When this is the case the boarding mother is seeking safety in an uncertain step". Some of the parents seen here had been foster-mothers to other children before adopting a child. They had sought to test the uncertain step first and, as they were people who needed to be appreciated, they had obtained much satisfaction from taking fairly short-term children. To be taken for granted however as an ordinary parent was too much for them and they finally rejected their adopted child. Hutchinson considers that of all foster-parents the boarding mother is the one deserving the greatest esteem—the adoptive mother has the advantage of legal possession.

Outside the scope of this study, two foster children seen here came from homes where a younger child had been adopted and it would be interesting to study further the motives of foster-parents who proceed to adoption.

Conclusion

The results of this study show that the underlying reasons for wanting to adopt a child were not fully appreciated by the parents. It is for consideration whether the way ahead in adoption lies in a better understanding by the parents of these reasons at the time of taking a child.

In the cases we regarded as unsuccessful adoptions the child had been rejected because he did not fulfil the parents' frustrated ambitions or their desire to be loved. Bowlby quotes Michael and Brenner's finding, "The six homes considered unsuccessful are, rather, homes where the child is either rejected or excessively over-protected and infantilised".

The problems and emotional difficulties with which we dealt in these cases were the same as those for children born to the parents. The possibility of inherited qualities offered an additional line of escape to parents seeking someone or something to blame for the problem. Normal reactions were intensified where the adoption took place for reasons other than as an outlet for motherliness.

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APPENDIX

NUMBERS

From September 1949 to September 1952	19
Boys	11
Girls	8

ADOPTIVE PARENTS

Hitherto unknown to child or his real family	12
Friends or acquaintances of the real mother	4
Maternal Aunts (Single)	2
Maternal cousin	1

AGE ON ADOPTION

6 months or younger	11
6 months to 3 years	3
At 6 years	3
At 10 years	2

SYMPTOMS

Behaviour Problems	13
Nervous	4
Educational	2

DIAGNOSIS

Anxiety State	13
Hysteric	2
Educationally Sub Normal	2
Psychopath	1
Psychosomatic	1

CLINIC ACTION

Treatment Cases		12
Closed improved	4	
Attending and improving	4	
Closed unco-operative	2	
Placed in residential schools after treatment	2	
Supervised at 3-monthly intervals		3
Closed improved	1	
Attending	1	
Recommended E.S.N. school	1	
Remedial Teaching		3
Closed improved	3	
Advice only		1
E.S.N. child for confirmation of diagnosis.		

MAIN DEFECT

Defect in mother	11
Defect in child (Constitutional)	4
Defect in child (Functional)	4

[The defects in the mother were considered important in 17 cases.]

RESULTS

Adoption successful	10
Adoption average	5
Adoption unsuccessful	4

[In two of the unsuccessful cases, adjustment of the child was obtained through residential schooling]

Case History of a Certified Mental Defective

By A. D. B. CLARKE, B.A., Ph.D., and A. M. CLARKE, B.A., Ph.D.
Psychologists to The Manor, Epsom, Surrey

Introduction

In October 1951 a 25 years' old patient was transferred to this Hospital from another institution. He had been certified as feeble-minded nine years previously and had spent most of the interim period as an inmate of two institutions. On admission here he was found to have an I.Q. of 114, despite his almost complete illiteracy. The history, subsequent progress and discharge of this young man, have important implications for mental deficiency law and practice and, in the writers' opinion, merit a special report.

History of the Patient from official documents

The patient, Z., was born in February 1926, and in 1933 at the age of 7 was graded educationally defective. Until 1942 he attended special schools, but he was then charged with "feloniously stealing a plane and two chisels of the value together of twenty-six shillings". This precipitated action under the Mental Deficiency Act, and he was placed under guardianship, the relevant medical certificates including nothing stronger than the following comments:

First Certificate

"He is childish in manner and speech: he says that George V is king: he says that Prince (sic) Margaret is the King's daughter: he does not know the number of days in the year: he cannot name other trees than 'elm' and 'oak': he is unable to define simple words such as 'haste', 'lecture', 'obedience': he cannot read some three letter words: he fails to observe qualities common to three objects such as rose, potato and tree."

"Previously I found that he had a defective knowledge of common facts and an inability to plan for the future".

"Miss . . . , Head Teacher of the . . . , Special School for mental defectives informs me that Z. is unlikely to make further progress at the school".

Second Certificate

"He knows his present age is sixteen, but answers 'Twenty-four' when asked how old he will be in five years' time. When asked in what way iron and silver are alike, he says that both come out of the ground, but cannot name any other resemblance between them. He states that the difference between a president and a king is that the president is head of the people while a king is not, and cannot state any other difference. He says that the present King of England is George the Fifth, but cannot say who the last King was. He cannot read at all, and when the letter 'C' was pointed out to him, he calls it 'Gee' ".

He was found to be "subject to be dealt with" under the M.D. Act by reason of the following circumstances: "He is found guilty of a criminal offence". The home conditions were said to be unsatisfactory; the household consisted of the mother, a widow, an elder brother, Z's twin sister (who was under supervision of the M.D. Acts department), Z. himself and a younger brother; the total income of the family was said to be £2 9s. 6d. per week. The mother was found unsuitable to have charge of Z., and she herself stated that he was beyond her control. An order was therefore made placing the lad under guardianship at a farm, but in 1944 he was sent to a mental deficiency colony having become "unsuitable for guardianship". In June, 1947 he was removed to another institution with better facilities for the custody of difficult patients since he had by this time become uncontrollable and was given to making thieving raids on the neighbourhood.

Upon admission to this second institution the patient's mental state was described as being that of:

> A "feebleminded person: mental age approximately 9 years. He seemed content with his lot and was not resentful at having been transferred. He settled rapidly to institution routine and discipline. He worked well and co-operated in every way. Early in 1949 he was removed to a villa for more trustworthy patients".
>
> In July 1951, his mental state was said to be as follows:—
>
> "He is well behaved, good tempered and amenable to discipline. He works well in the Metal shop. He states that he is anxious to return to X... Colony and make amends for previous lapses. His Mental Age is assessed at approximately 9½ years".

Results of psychological investigation at The Manor

Upon admission to this Hospital in October 1951, Z. was given a routine psychometric test, followed by a more detailed investigation. The results of the Wechsler-Bellevue Intelligence Scale for Adolescents and Adults were as follows:

Verbal I.Q. 102. Performance I.Q. 124. Full Scale I.Q. 114.

Despite the patient's lack of informational experience, illiteracy and educational handicaps, which cannot but have placed him at some disadvantage in this test, many of his answers were of high quality e.g.:

> Q. If you were lost in a forest in the daytime, how would you go about finding your way out?"
>
> A. "I would head north, by looking at the moss on trees which faces north".
>
> Q. "Why should people pay taxes?"
>
> A. "To pay for parks, schools, roads, Parliament wages and so on".

He scored well on mental arithmetic, and his power of abstraction was good.

His vocabulary was of surprisingly wide range despite his illiteracy; but his vocabulary score was the lowest of the verbal sub-tests; his highest score was obtained on the block-design test,

where every problem was solved correctly, and all but one received extra credits for speed.

On the Burt Reading (Accuracy) Test, his Reading Age was 6.0 years.

The record of the Rorschach Psycho-diagnostic test was of interest but is too full to give here. The responses were intelligent, but highly constricted, and give evidence of an anxious, introverted and disturbed personality; there were some indications of homosexual tendencies.

Z. was regarded psychiatrically as being of markedly schizoid personality; his body-build was asthenic.

Because of his exceptional ability he was given special tuition for at least one hour daily. His account of his case history was summarised thus:

"I lived at E . . . till I was 12. I must have started school at 5, and went to . . . Catholic School. I was there for three or four weeks, and then I went to a special school.

"My father was a corporation dustman. Mother was a cripple. My elder sister looked after the family as far back as I can remember until she got married when I was about 10.

"When I was about 4, I got on to a railway bridge and got caught by the station master. I was very sorry for myself because I thought he was a policeman.

"I didn't play truant from the Catholic School; I think I was put into the special school because I was at that time very slow at reading and arithmetic, but I improved a lot from about 8. At the special school I did mostly handwork. I found it very interesting, but didn't like carpentry, I couldn't get on with the master. I had a bad temper at school but not at home. When I was about 7 I threw a desk at the school-master.

"I argued a lot with my twin sister. Most of my brothers and sisters had left home before I was born. I am not sure how many there are, I only have Mum's word for some of them, but I have *seen* three brothers and four sisters.

"At home it was a corporation house; there was a living room, bath-room and scullery downstairs, and three bedrooms upstairs. I've always made very few friends.

"My reading teacher was very grumpy when I was slow at picking it up, so I started to play truant. Sometimes I went for a day every week and sometimes for two or three. I was slower than the other lads at the special school at reading. My arithmetic improved though. We had to make designs from measurements the teacher gave us. My twin sister was at school with me; my younger sister did not go to a special school.

"When I was about 10, Mum started to walk with a stick; I don't know what was wrong with her before that.

"I played up at school with the headmistress, so two big lads were called on to fetch me and take me to the barber's to have my hair cut because she said all my strength was in my hair. I was the worst boy in the class and the black sheep of the school.

"My father was very strict and wouldn't let anyone spoil us. I wasn't exactly frightened of Dad, more frightened of his belt than anything, but if he had hit me a bit harder he might have done me more good. I lost him at the wrong age, when I was getting on for 12. When Dad died, Mum bought another

home in a different part of the town, but things got bad, and she had to sell it. From then on it was always moves. In 1939 we went to B . . . and moved from house to house. After we moved there Mum lost the address of my next youngest brother who had been in an approved school for years, and we didn't get contact again until 1942.

"The special school at B . . . wasn't as bad as the other, but I was once wrongly accused of breaking into it. I got on well at sums, but not at reading. I wasn't very keen on hand-work unless I made my own design—the smaller the object the better I like it. I didn't play truant as much as before, only when there was a good film on. After the age of 12½ trouble started. Winnie (eldest sister) died, and Mum went to the funeral. I had to look after the other two who were very scared of the dark; they wouldn't go to bed, so we sat up all night. Mum came back next day.

"The first time I stole was when I took floorboards from a building estate; I wanted them to make furniture for home—it wasn't very good furniture, but it was my own plan and it looked tidy. I was caught and put on probation and the Probation Officer came to see me once. I went straight for a year, and then got caught breaking into school. We didn't do any damage, and it was only a bit of fun. I got caught again, and got more probation. This time I never saw any of the probation people. Then I stole some carpenter's tools and was sent to foster parents and did six months with them . . .I was homesick, and ran away . . . I got caught on a bombed place, 'looting' as they call it, collecting firewood.

"Then they put all the cases into one and decided to put me away. I went to a farm in the country, and did milking and land work. I ran away but when I got home there was a big policeman waiting for me. I was sent to X . . . Colony. I ran away pretty often, nearly always on my own; I usually stole bikes to get a long way away. Twice I went out on licence, but twice had it stopped. First time I 'loaned' one of the college boy's suits. I was doing kitchen work and got 7/6 pocket money, and 15/- in the bank. The second time I took a suit, it was for a party and I was going to put it back that night; I got sent back to the institution.

"After about nine months I was sent on licence to a hotel; it was blitzed. I walked around and found some old-fashioned medals; I picked two up, was caught and sent back. Two or three times I ran away but was caught. I was never violent, my temper had calmed down by this time. I stole some money from a school and then got a part-time job painting and working for an odd-job man.

"A few days after leaving X . . . Colony my brother told me they were waiting for a vacancy at another institution for me. I knew this meant trouble, so I decided to have a nice long holiday before I went there. After three months I decided to give myself up to stop Mum getting into trouble. I was getting on for 21, and I could see that I would never get on being dishonest. So I gave myself up, decided to take my punishment and go straight.

"I got sent to the other institution; they do a lot of these patients good there, and you are not picked on for doing nothing. There were one or two black spots, but I kept my tongue between my teeth and my hands in my pockets, so I was O.K. I was at the tin-smith's for three and a half years; it did me a lot of good

and I should have had it earlier. That's partly the trouble with local institutions, they are not strict enough."

He also said he liked men better than women and had never had a girl-friend nor a close man friend.

Asked if he dreamed much he said: "No, not very often. Most of them end up with a big fall, and I find myself at the bottom of the bed. I often dream I'm climbing up a rock, and I slip down and wake up as I'm falling. They say that if you don't wake before you hit the bottom you die of shock. Once I dreamt that I was saving a bomb under a train. The bomb was under the wheels, and I went to throw it away. It went off, and I woke up. Most of my dreams are either unpleasant or exciting. It is a long time since I had a dream".

Results of Special Tuition

Z. at once began to make steady progress at reading and writing. Within a few weeks he had written without help his first letter, and he spent most of his spare time in study. The remainder of the time he worked in the tin-smith's shop, where his practical ability was outstanding. After only two months' work his reading age (Burt's test) had increased by three years, and he became capable of reading simple books and newspapers.

Faulty pronunciation contributed to his difficulties in spelling. For instance, he pronounced "thought" and "fought" identically and accordingly spelt them the same way. The hospital speech therapist, however, was able to improve his diction.

No formal tuition in arithmetic was necessary.

On receipt of a special report from the Physician Superintendent, the Board of Control ordered the discharge of Z's Order with effect from the 25th December 1951, but the patient asked to be allowed to remain as a " guest" for a week or two longer in order to pursue his studies, and in January 1952 a job was obtained for him in a hotel about ten miles away.

Z. has maintained contact with the writers and occasionally visits them for additional reading tuition. He considers that his reading must be further improved before he can gain full advantage from a course of study at a technical college, which is one of his ambitions.

Discussion

Z. is essentially a schizoid type with a record of emotional instability and delinquency. He has successfully overcome many of his handicaps and seems likely to make an intelligent and useful citizen, although one cannot entirely discount the possibility of a future mental breakdown. While it is possible that Z. was the victim of deferred mental maturity of the type discussed by the writers in a paper awaiting publication, it is possible also that emotional disturbance in childhood, resulting from adverse environmental conditions, contributed to his retardation and masked a

superior intelligence. It will have been noticed that the medical reports which supported Z's certification were based largely on his answers to questions which assumed implicitly that the subject of investigation had the requisite informational experience at his command. Granted average opportunity, attainment and capacity are usually closely associated, but when opportunity to acquire information is restricted then answers to such questions may give a misleading impression of the individual's intelligence. Furthermore, it is clear that the Mental Age of 9½ years, attributed to the patient much later, misrepresented his cognitive ability. Thus, lacking any precise psychometric date for this patient before he reached manhood, it is impossible to trace his mental growth except in terms of probability.

The Mental Deficiency Act (1927) defines mental defectiveness as: "A condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury." Feebleminded persons are those "in whose case there exists mental defectiveness which, though not amounting to imbecility, is yet so pronounced that they require care, supervision and control for their own protection or for the protection of others, or, in the case of children, that they appear to be permanently incapable by reason of such defectiveness of receiving proper benefit from the instruction in ordinary [1]schools". Further, the individual must be "subject to be dealt with" if action is to be taken under the Act. Z.'s failure at school, his inadequacy in dealing with the informational problems set by the two certifying physicians, his emotional instability, 'awkward' personality traits, his record of behaviour disorders and the educational defectiveness of his twin sister, presumably all contributed to, and resulted in, the diagnosis of mental defectiveness. Since he had rendered himself "subject to be dealt with" by having been convicted of a felony, statutory requirements were thus satisfied, the law took its course, and detention under the Act followed.

As the law and administrative practice conspired to place Z. in the same institutions and under the same protocol as low grade aments, he became implicitly the subject of the gloomy prognosis of the majority of mental defectives in institutional care. Having passed school leaving age, he was for years denied the opportunity of acquiring the informational experience and education which would have assisted him to develop and demonstrate his latent potentialities. Ultimately, however, he achieved a high degree of insight, responded well to discipline, and earned his transfer to an institution with facilities for full psychological investigation, educational and other types of training, and as soon

[1]*The Education Act (1944) has in effect amended this definition.*

as he was given this opportunity he made the rapid progress already described.

This case history indicates the necessity for adequate team work on the part of social workers, psychologists, educationalists and psychiatrists in dealing with the lesser degrees of social and mental subnormality. With fuller investigation in childhood and adolescence and more consideration of the environmental factors involved, Z.'s career might have been very different. This case raises the question of how many others there may be certified who, unlike Z., lack the opportunity to succeed.

Assessments require considerable time for their completion, and rapid examination often under conditions of emotional stress, may yield results which have no great diagnostic or prognostic value. It is therefore suggested that residential centres adequately staffed with experts should be established for the observation of such cases over periods not exceeding one year. Furthermore, it is essential that certified high-grade patients should no longer be dealt with in the same institutions as idiots and imbeciles, since their prognosis and needs in terms of education and training differ so greatly. It is important, too, that there should be wider recognition of the fact that in a proportion of feebleminded patients "a condition of arrested or incomplete development of mind" does not necessarily imply a permanent failure of mental growth.

The writers wish to express their thanks to Dr. J. F. MacMahon, Physician Superintendent, for his great help and advice in the preparation of this paper. They are also very grateful to Miss Maryse Israel, Psychology Department, Maudsley Hospital, for her valuable comments.

Psychiatric Community Care in London

The London County Council is now administering its own scheme for this service (for which it formerly used the National Association for Mental Health and the Mental After-Care Association as Agents), and has recently announced details.

The Mental Health Section of the Council's Public Health Department is responsible for organising the work, and patients are visited by its psychiatric social workers on the understanding that such help is desired and that the prior consent of the family doctor has been obtained. The patients entitled to the service are those who are not in need, or further need, of out-patient or in-patient psychiatric treatment and its object is to prevent serious breakdown or relapse and, where necessary, to ensure that treatment is sought early.

Notification of cases considered to be in need of help should be sent to the Medical Officer of Health (PH/B.1), County Hall, S.E.1, accompanied by a statement that the patient is willing to receive it.

News and Notes

"On the State of the Public Health", 1951

In our Autumn issue we noted the publication of Parts I and II of the Annual Report of the Ministry of Health—Part I on the National Health Service covering the period, 1st April to 31st December 1951, and Part II "On the State of the Public Health" covering 1950 only. Now comes Part III in which the Ministry Chief Medical Officer brings his own report up to the end of the period covered by Part I, so that we have the complete record for these years (a mere eighteen months late!)

In this volume there is one chapter on "Mental Health" consisting of seven pages, the first six dealing with mental illness and the seventh with mental deficiency with a short final paragraph on Epilepsy. In the subsequent chapter on "Nursing and the Public Health" there are two short paragraphs on mental hospital staffing.

The points discussed include the recurrence of mental illness and it is noted that in a mental hospital where the proportion of voluntary patients is low, the recurrence rate tends also to be low. One explanation of this is suggested, viz. that the tendency to recurrence is greater in psychoneurotics than in psychotics, and that voluntary patients are apt to discharge themselves too soon before their recovery is complete. This, of course, is particularly likely to happen where the amenities and standard of care are unacceptable to the recovering patient, but we scarcely think that the statement would be confirmed by hospitals which are served by adequate staff and an adequate follow-up service.

In connection with the high proportion of elderly patients admitted to mental hospitals (in 1938: 3,363, as compared with 7,280 in 1948) it is suggested that it may be in part attributed to loss of beds formerly available in public assistance institutions, to lack of adequate housing, to increased employment of women and consequent lack of facilities for home care, and to less willingness to accept family obligations. The value of appropriate treatment is stressed, and attention is drawn to an enquiry made by the Geriatric Committee of the Royal Medico-Psychological Association into 600 admissions of patients aged 65 or over, of whom after 2 years, 42% had been discharged, 38% had died and only 20% continued in residence.

Under the section "Treatment", reference is made to Occupation Therapy, psychotherapy, clinical psychology and out-patient clinics.

The subject of Mental Defect is dealt with only briefly. Some figures are given showing that in 1950, one half of the patients admitted to institutions "were unable to give themselves the every-

day care needed for dressing, washing and generally keeping clean", and referring to the tendency for the proportion of low-grades to rise. Commenting on Licence it is emphasised that this should be regarded as a step towards discharge and should not continue indefinitely.

A paragraph on glutamic acid quotes an experiment in which this was given to some children and adults in a mental deficiency institution with a control group of normal children. It was found that there was some "slight but equivocal" evidence to suggest that the cognitive functions of one group of normal boys were improved, but apart from this no improvement could be measured by tests of cognitive function or personality.

We note in the June issue of the Fountain Hospital Bulletin that its Hospital Management Committee has drawn the attention of the National Association of Hospital Management Committees to the "paucity of published statistical information relating to the Mental Health Services". With this contention we would agree and we would not wish to limit it to statistical information only. Moreover, the way in which the required information is presented —distributed as it is between different reports published at separate intervals—makes the task of discovering and collating it one of considerable difficulty.

The Nursing Situation

The Ministry of Health has recently issued a Circular (R.H.B. [53]54 : H.M.C. [53]50) on the "Supply of Nursing Staff for Mental Hospitals and Mental Deficiency Institutions", making some suggestions for improving the present situation which is described as "in some respects tending to get worse rather than better", although the general hospitals have succeeded in attracting more recruits.

In dealing with the selection of candidates for training as student nurses, it is suggested that applicants should be scrutinised more closely and that those who appear unlikely to reach the required standard should be offered employment in a subordinate grade. In anticipating the criticism that this would encourage dilution and a deterioration of standards, it is pointed out that the employment of student nurses who fail to qualify is itself a form of dilution and that the number of young persons with the necessary educational qualifications for full training is not great enough to meet the demands for them whether by the nursing or by other professions.

It is therefore urged that the direct engagement of more nursing assistants should be encouraged but that hospitals should provide for this grade a definite course of instruction. (Some suggestions as to the type of instruction envisaged are added in an Appendix). Proposals that there should also be facilities in mental hospitals as there are in general hospitals, and for the training and

employment of enrolled assistant nurses are noted and the General Nursing Council's requirement that included in such training must be experience with infants and young children, as a result of which no mental hospital has so far been approved for the purpose, is referred to without comment or criticism. This subject is a controversial one and good arguments may be adduced on either side, but we welcome the Ministry's official encouragement of the principle that training of *some* kind should be given to those not capable of taking the full nursing course.

The Circular announces that two mental nursing officers (a man and a woman) will shortly be added to the Ministry's staff. Under the direction of the Chief Nursing Officer these will be concerned with problems connected with nursing in mental hospitals and mental deficiency institutions.

Reference is finally made to schemes of training for the double qualification of general and mental nursing which have been advocated and which it is understood would be sympathetically considered by the General Nursing Council. There is however no reference in the Circular to a further suggestion, viz. that in the training of a general nurse, some experience of mental hospital nursing should be a component part. Might not such a provision do something towards attracting recruits to a field of service which in part owes its unpopularity to the fact that it is unfamiliar?

Finally the circular avoids any attempt to deal with what many regard as the greatest factor responsible for the shortage, namely the inadequate salaries of the nursing profession. Married men will scarcely take up mental nursing if their starting rate of pay does not allow them to survive.

A Mental Hospital Today

That a mental hospital can be a focus of mental health education and a hub of cultural and recreational activity as well as a centre for the clinical treatment of mental illness, is strikingly shown in the pages of the current Annual Report of the Winwick Hospital, Warrington.

The section on "General Rehabilitation" includes a weekly programme of social events of various kinds, whilst the Education Department records the success of the open educational evenings which attract audiences of between 50 and 250. On outings to places of interest, patients have been received with "enthusiasm and open-handed hospitality". The Library's "Interest Room" has exhibited ten displays of various kinds during the year, and possesses over 500 gramophone records of which some 300 are of classical music.

An Intensive Rehabilitation Scheme is in force for patients requiring it, and for this purpose there are 12 special groups each containing from 20 to 30 members. These Groups have definite

(and different) programmes assigned to them, including Occupation Therapy, Physical Training, Group Games, Education, Day Entertainment and part-time utility work. For the very deteriorated patients there are Ward Classes of a more elementary type. To direct all these activities there are two education officers, four occupation therapists and four physical training instructors, and of the ambulant patients, 95% of the men and 72% of the women are occupied or employed in some way or other.

An increasing number of patients are allowed Parole and every week-end there are some 100 patients on leave. Friendless patients are visited at intervals by workers from the Warrington Council for Social Service.

In common with other hospitals there is a shortage of nursing staff made more acute by the fact that extra nurses are now needed owing to the increasing intensity of medical treatment given in the wards and the fact that so many patients have to be escorted to ancilliary departments for various forms of treatment.

Dr. Nicole refers in his report to the type of patients received from the Courts under the Criminal Justice Act, some of which he finds are not really suitable for a mental hospital as they suffer not from mental illness but from "a personality immaturity which cannot be treated". It would be interesting to know what is the experience of other medical superintendents in this connection.

The Report ends with a statement on the part played by the Hospital in educating the public. During the year, 50 talks were given by senior members of the staff to a variety of voluntary bodies which have aimed at explaining the nature of mental ills and its treatment and correcting current misunderstandings. This propaganda work, carried on for many years, has met with keen response and it is felt to be one of the Hospital's most important functions.

British Epilepsy Association

This Association is holding a Course on "Epilepsy" at Holly Royde Residential College, 30 Balatine Road, Withington, Manchester, on Thursday and Friday, October 29th and 30th 1953.

The Course, which it is anticipated will be recognised by the Ministries of Health and Education, is intended to be of interest to those whose work brings them into contact with epileptics. Speakers will deal with varying aspects of the problem—medical, educational, industrial and social, and it is hoped to arrange visits of observation to colonies, special school and training units.

A limited amount of residential accommodation is available but early reservation should be made. Further particulars will be sent on application to Miss Irene Gairdner, General Secretary of the Association, 136 George Street, London, W.1.

The Association's Second Annual Report which has recently been issued, gives an interesting account of its increasing activities.

Association of Child Psychotherapists (Non-Medical)

This Association was formed in 1949 in order to co-ordinate the training and maintain the professional standards of those engaged in child psychotherapy. The Association wishes it to be known that after December, 1953, applications for membership will only be accepted from those who have been trained at a recognized Training Centre. Two have so far been recognized by the Association:—The Hampstead Child Therapy Clinic (Director: Miss Anna Freud, Ll.D.); and The Tavistock Clinic (Director Children's Dept.: J. M. Bowlby, M.A., M.D.).

Until December 1953, applications are invited from those who have an adequate academic background, and long experience in child psychotherapy under psychiatric supervision such as might be considered to amount to a training. Anyone interested is asked to write for an application form to the Hon. Secretary, Association of Child Psychotherapists (Non-Medical), 39 Queen Anne Street, W.1.

Mental Deficiency Discussed in Parliament

On May 7th, in answer to a question from Mr. Bernard Braine, (Member for Billericay, Essex), the Minister of Health stated that on 31st December 1952, the waiting lists of Regional Hospital Boards totalled 8,714 mental defectives of whom 4,487 were children. The recognised bed space in institutions was 50,401; the occupied bed-space was 53,914; the bed space out of use was 1,921.

An adjournment debate took place on the same day (Hansard, May 8th), raised by Mr. H. Hynd (member for Accrington) on the lack of mental deficiency hospital accommodation. In presenting his case, he drew attention to the new provision for Short Stay Homes but regretted that their use by Local Authorities was limited by reason of the fact that if grant-aided expenditure was involved it must be offset by savings on other parts of the service. He urged the extension of community care, an increased use of licence and guardianship, and the setting up of hostels for selected patients not needing institution treatment.

In her reply the Parliamentary Secretary to the Ministry of Health stressed the fact that priority in capital expenditure was being given to the mental health services, and she quoted as examples, the Leeds Regional Hospital Board which in a two-year programme had allocated £102,000 to mental deficiency out of a total expenditure of £190,000, and the East Anglia Board which had allocated for 1953-4, £49,000 out of £181,000.

In the Ministry's capital programme top-priority had been given to the building of Greaves Hall, near Southport, in which 1,040 beds were to be provided—a project which would take 5 years and would cost £3 million.

On the question of providing Hostels, the answer given was of a very ambiguous non-committal nature.

> "On the local authority side," Miss Hornsby Smith said, "it is a dual responsibility. A part of it is provided by the local authorities and a part by us. There is certainly encouragement for them to help, though possibly the accent is on the educationally retarded side rather than on the mental side."

What exactly this means, it is not easy to gather.

Doctors and Clergy

A meeting of a kind which is still surprisingly uncommon was held at Grimsby early in May, when a group of local clergy of various denominations was invited by the British Medical Association branch to a discussion on "Anxiety States and the Modern Attitude to Life". This joint meeting was both large and representative.

The Editor was invited to open the discussion which centred on the suggestion that behind psychoneurosis was often a lack of faith in any outside influence. The amount of agreement and common interest between doctors and clergy which was recorded seemed to be a surprise to several of both parties.

Children's Officers and the Family

A Report recently issued by the Children's Officer of the City of Birmingham under the title "The First Four Years", should give reassurance to those who feared that one effect of the Children Act 1948 might be to facilitate the break-up of family life.

In the section on "Family Case Work" great stress is laid on the need for exploring every other possibility before a child is separated from his family circle. Frequently it is found, we are told, that the help of neighbours, friends and relatives is forthcoming if efforts are made to enlist it. This applies even to children technically removed into care, and during 1952, 64 such children were amongst those boarded out with relatives or friends previously known to them. In co-operation with relevant departments of the Local Authority other solutions are also sometimes found, e.g. the provision of a Home Help to tide over a crisis involving the absence of the mother; the admission of young children to a day nursery; arranging with the welfare officer concerned for a father to change his working shifts or to be given extra time off so that he may attend to his family. In the case of the unmarried mother equal efforts are made to keep her with her child.

Referring to the problem of the homeless family, it is found that "those who are genuinely homeless can usually deal with their

own problems and that the remainder could prevent their homelessness occurring with a little extra thought and planning".

Even if children have to be taken into care, case-work continues in the hope that ultimately they may be reunited with their families, and a great many children have been returned to their parents.

In cases where a problem is due to difficulties of personality, the co-operation of the City's Psychiatric Service, the Probation Service or the Family Service Unit is sought.

The Report should be studied in its entirety by all who are interested in the work of Children's Officers and in the administration of the Children Act. It can be obtained (price 2s. 6d.) from the Children's Officer, 102 Edmund Street, Birmingham, 3.

Reviews

Psychoanalytic Studies of the Personality. By W. Ronald D. Fairbairn, M.D., F.R.S.E., F.R.A.I. Tavistock Publications. 25/-.

This book consists of a series of papers written over a period of 20 years. Some articles have recent postscripts which make clear the author's present standpoint over questions about which his more recent views have deviated or progressed some considerable distance from his earlier ones. The work is divided into three parts, the first and largest being devoted to papers on the theory of personality structure. The second part consists of clinical papers and the third part of papers on applied Psycho-Analysis.

The whole volume shows the author to possess keen powers of observation, a highly original and cultured mind, and a method of approach which always is stimulating though sometimes provocative.

Parts 2 and 3 do not display to such a marked extent the more original views of the author, partly because some of them are earlier papers written when his views had not become so clearly differentiated from the main body of psycho-analytic thought based primarily on the work of Freud. Part 3 contains an excellent article on war neurosis written in 1942, which designates separation anxiety as the prime factor in the war neurosis, and, furthermore, states that there is a synergic action between a persistence of infantile dependence and hence a special susceptibility to the stress of separation anxiety on the one hand, and a specific traumatic experience on the other. He rightly states that the importance of the traumatic experience is in its specific and personal meaning to the individual who sustains it.

In Part One, Dr. Fairbairn works out his thesis that libido is primarily object-seeking rather than pleasure seeking. The pleasure principle is jettisoned. He does not see the need for Melanie Klein's explanation of the cathexis of internalized objects in terms of Life and Death instincts, but believes that the phenomena attributed to the work of a Death instinct can better be explained if they are regarded as the products of a sado-masochistic relationship with an internalized bad object. He explains the "Repetition Compulsion" in terms of a continued relationship with an internalized object.

Having started off with the idea that Libido is object-seeking, he works out the implications of this with great courage refuting Freud's theoretical formulations where they do not fit in with his own findings. He demotes Abraham's phases of emotional development, with the exception of his oral phases, as being really techniques employed by the ego for regulating relationships with objects and in particular with internalized objects. He regards development as being from a state of infantile dependence on one object, i.e. the mother, characterized by primary identification, that is a lack of differentiation, between the self and the object, through a transitional stage, to a stage of mature dependence upon objects. At this state the differentiation between the self and the object is much more complete.

He discusses the relationship of Freud's views to those of his contemporaries in the physical sciences and asserts that great though Freud was, he could not go beyond the bounds of Helmholtzian physics in which matter and energy were regarded as being quite separate. Fairbairn relates his theory of Dynamic Structure of Personality to the physics of today where energy is not divorced from matter, but so intimately bound up with it that the two are inseparable.

The author worked out a theory of Endopsychic structure which he regards as consisting of a central ego, two split off parts, viz., an internal saboteur (related to, but not identical with, the super-ego of Freud), and libidinal ego (related to, but by no means identical with, the id of Freud). The internal saboteur is related topographically to the rejected component of the originally split internalized object, and the libidinal ego related to the exciting part of the originally split internal object.

This is the most original part of the book and the part which is likely to evoke the most controversy, nevertheless, the detailed working out of the object-relations theory of personality is most stimulating, and should be provocative to further research. One is unlikely to agree with all that is said, but one cannot fail to be impelled into considerable thought. Moreover, the author approaches the problems of group behaviour in the light of his theory of personality structure, and thus offers much to the subject of social psychiatry. A.H.W.

Adolescence to Maturity. By Victor Chamberlain. The Bodley Head. 7/6.

This small book is another in the stream of information and advice to the adolescent. It is not easy to review except in terms of the curate's egg, for it is an odd mixture. In his foreword Mr. Chamberlain makes it clear that only one chapter is directed to the teacher—that on Sex, Love and Marriage; but this chapter is the best in the book and will help not only the teacher teach, but the adolescent (of all ages) overcome some of the common sexual difficulties; it is perhaps a pity that the author says little of the emotional and spiritual side.

Of his other chapters the largest is Some Hints to the Art of Living, and indeed these two occupy over two-thirds of the book, and it is not quite clear why these chapters on Work and Leisure and Attitude to Life are separated. These hints consist of a series of headings. Imagination. Be Just. Facing the Facts; under each is a concise and often epigrammatic set of maxims. There are a few inconsistencies but it would be unfair to take them too seriously and apart from them, the statements are unexceptionable. What matters more is the effect they will have on the adolescent to whom they are addressed. Mr. Chamberlain has been too strict and too concise, and his material will be too indigestible; one feels he has not sat down to think hard enough what he wants to say nor the needs of his audience, and has been carried away by his own brilliance to collect a glittering array of gems without a thread to string them on. Paradoxically, this part of his book may be more valuable for the teacher—and it will be valuable—though this is the opposite of his aim. R.F.T.

To Define True Madness. Commonsense Psychiatry for Lay People. Henry Yellowlees, M.D., F.R.C.P., D.P.M. Sidgwick & Jackson. 12/6.

This is a book written out of a very proper exasperation at the widespread misapprehension and ignorance with which the work of the psychiatrist is greeted today. Though the general public provides the background, it is the complacent generalisations of an ill-informed and pontifical legal profession which have generated the heat out of which Dr. Yellowlees has written. It is to be hoped, but not, alas, expected, that he may be widely read not only among the general practitioners but also by the august administrators of the Law! It is a not unnatural result of this preoccupation with the Law that the chapter on the legal aspects of insanity is by far the best in the book. It ought to have a salutary influence on that long overdue re-assessment of the position which the Straffen case, the subject of a characteristically pungent note, has forced upon all those both professional and private who are concerned with the administration of justice.

As a general introduction to the subject of psychological medicine at a very "popular" level, the book has the competence which we would expect from its distinguished author. Those who are already in possession of the information which he makes so lucidly available will read it for the pleasure of witnessing the doughty blows struck in defence of a much maligned profession.

In criticism it may be said that Dr. Yellowlees tends, perhaps unintentionally, to undervalue the immense contribution which analytical psychology has made to the stock of concepts with which the psychiatrist is enabled to handle his difficult material, while leaving the reader in no doubt of the harm which has been done to the science generally by a sensational exploitation—for which Freud himself cannot entirely escape responsibility—of the theories in which these concepts first succeeded in gaining currency.

While the choler which drives the author's pen results in a certain degree of repetition and an occasional lack of balance between the polemical and educative elements, it would be wrong not to emphasise that Dr. Yellowlees has written an extremely readable and often very funny book. P.W.B.

Broadmoor. A History of Criminal Lunacy and its Problems. By Ralph Partridge. Chatto & Windus. 21/-.

One is so accustomed to the unpleasing picture of Broadmoor painted by what the author refers to as the sensational Press, that it is indeed refreshing to read this factual and unbiased account of the life of the Broadmoor patient, his work and play, and the surroundings in which he lives.

The author has clearly approached his subject as a novice seeking information, and has been surprised, usually favourably, by what he has found. Though at times he goggles unashamedly at some of these unfortunate humans, both as regards their appearance and their behaviour, he performs his task sincerely, and tries to avoid being sensational himself. His descriptions are sometimes too detailed, and one feels he could well have omitted his graphic descriptions of electro-convulsive treatment, especially performed with obsolete technique. In view of the thousands of such treatments given in mental hospitals throughout the country, readers who are relatives of patients, or even patients themselves, may well be discouraged from undergoing future such treatments. At the beginning of the book the legal considerations are neatly discussed, and the reader can quickly appreciate the occasional difficulties which arise in the interpretation of the MacNaughton Rules. I also found the history of the Institution and the lives of its Medical Superintendents of great interest.

When we come to medical matters however, the author often flounders, and soon illustrates that a little learning is a dangerous

thing. For example, one cannot allow to pass unchallenged his dogmatic assertion that "the vast majority of those who take human life are in some degree mad", even though he does include the homicides who also commit suicide, and those who only kill themselves. In the series of 94 prisoners charged with murder to which he refers in his book in connection with the E.E.G. examinations, 46 had no psychiatric history whatever, and a large number of the remaining 48 had only minor personality defects. Again, how many psychiatrists would agree with his definition of the psychoneurotic as "suffering from some minor mental disturbance not amounting to certifiable insanity", or that hysteria is "essentially a feminine weakness"? Again, he alleges the condition of psychopaths "tends never to get worse—or better" though he states in another context that some time after the age of fifty a psychopath may become more adult and be emotionally grown up.

To the medical reader these inaccuracies mar the book; the pedant also may well criticise the literary style throughout. But when in conclusion the author hopes he has helped his readers to fear Broadmoor patients less and to understand them better, one agrees wholeheartedly that the book has not been written in vain, and deserves to be widely read and studied by the general public.

F.H.T.

A More Excellent Way. By Leslie J. Tizzard, B.A., B.D. D.Litt. Independent Press Ltd., Memorial Hall, E.C.4. 7/6

For an indication of what is meant by "mental health" enquirers are rarely referred to the New Testament, and this book should help to bridge the chasm which too often yawns between those who seek guidance from "religion" and those whose sheet anchor is modern psychology.

Dr. Tizzard takes as his theme St. Paul's great Hymn of Love in the thirteenth chapter of Corinthians I, showing its applicability to our individual everyday lives and particularly its bearing on the psychological problems of human relationships in which we are all involved. Taking "love" in its widest sense, as in the first instance a matter of the Will, he discusses—in the light of his long experience as a minister of religion—the factors in our make-up which cause us to sin against it.

The sensitive reader must therefore inevitably be subjected to a searching test and the issues raised are discussed in language so personal and free from technicalities that they cannot be evaded. But if he persists to the end, he will find that the last of these 17 short chapters is concerned with the spiritual foundation upon which St. Paul's glowing affirmations are based and with the exultant faith in the sure and certain hope of ultimate fulfilment which makes this business of learning to love an adventure upon which we can confidently embark.

A.L.H.

One Little Boy. By Dorothy M. Baruch, with the collaboration of Hyman Miller, M.D. Gollanz. 13/6.

This is the story of the treatment by a clinical psychologist of a seven year old boy who suffered from asthma. Although the case material is used to illustrate the boy's unconscious phantasies, his hidden aggression and sexual wishes, the form used is more that of a novel. A good deal of skill is employed in rounding off each chapter and in starting the next with a vivid happening and the plot is enhanced by the novelette stories of both the parents who at the same time are being tempted to break their marriage vows —figures which might have stepped out from a Hollywood film.

We are assured this is a true story and that nothing has been attributed to Kenneth which he did not say or do. At the age of 12, he read and checked the manuscript (heaven help him!). To English readers however, the form in which the book is presented, the cheap drama of the parents' encounters with the opposite sex, and indeed some sentimentality about the boy, make it hard to accept it for the serious case study which it is.

There is real value in the repeated emphasis on the fact that all children have hostile thoughts against their parents, intense jealousies, fears and sexual phantasies. The harm does not lie in having such thoughts but in not being able to master them so that the struggle to repress, and the guilt and anxiety involved, render a child unable to progress. Kenneth was unusually intelligent, but failed in school. His physical development was hampered by the choking of his asthma. In the play therapy sessions, he is seen working out his relationship with the psychologist, expressing his morbid fancies and venting his aggression, while the asthma attacks act as a barometer of his progress. His reactions to his parents and his half knowledge of their problems are cleverly indicated. The whole picture is lucid, all the parts fitting together and receiving explanation.

Whether unenlightened parents who read the book will benefit from the sound psychological principles which are its backbone, or will stop at easy, factual explanations of the situations presented is a question. The danger of the "novelette" form is that it offers too easy superficial explanations. The great novel gives a universal truth, and science also works by laws which can be applied to any case. But such principles exist in this book and it reveals the author's own warm humanity. R.S.A.

The Social Services of Modern England. By Penelope Hall. Routledge and Kegan Paul. 25/-.

This is a worthy addition to the International Library of Sociology and Social Reconstruction. It is a monument of careful labour in the collection of facts from relevant fields, and comments from recognised authorities. The classified bibliography and sug-

gestions for further reading add to its value for the student. There is also a detailed index, though its headings are somewhat arbitrary and it is surprising not to find such well-worn topics as "boarding-out" or "foster-homes" listed. For these reference has to be sought under "Children deprived of Home Care".

The development of the social services is outlined and their present application described with a wealth of detail, some necessarily already out of date (e.g. rates of Family Allowances). The special claims of classes of person such as the aged and the young, are considered as are also the generic needs of a community or neighbourhood. How to balance the demands of the individual and of the group, where to draw the line between freedom and control —these are the perennial problems of social work. Changing conceptions of the role of the social worker have altered and are altering her function and consequently altering the demands made on the schools of training. Here there are conflicting ideas and needs which Miss Hall mentions but also in which she does not give a bold lead.

Indeed the erudition and careful compilation of the author seems to have left her still unsure. She has searched every authority and gives quotations for the most ordinary opinions, yet she seems to lack confidence that the reader will follow her, though the book's innumerable footnotes weight the pages and many refer to previous or subsequent chapters in general, not to any difficult point which requires a cross reference. But she should be reassured that her book will be read from cover to cover by serious students who will wish to keep it by them for reference. They may not however, share its apparent acceptance of the benefits of more, even of better, social services, supervision and organisation. Might not the object of social services be to help people to do without them?

R.S.A.

Muscle Relaxation as an Aid to Psychotherapy. By Gerald Garmany, M.B., Ch.B., M.R.C.P., D.P.M. The Actinic Press, 356 Kilburn High Road, N.W.6. Cloth 5s., Paper 3/6.

This book is a brief account of a method of inducing muscular relaxation in anxious people in order to bring about reduction in mental tension. It is addressed to the physiotherapist, and is simple, straightforward and easily comprehensible. There are chapters on the mechanism of emotion, bodily symptoms of anxiety, and muscle tension. One chapter explains in detail how relaxation is to be induced. Anxiety and tension are the principal indications for relaxation treatment, and the uses and difficulties of the method are discussed. The psysiotherapist is advised not to engage herself emotionally with the patient or to undertake psychotherapy. The book should be required reading for all students of physiotherapy.

D. O'N.

Backwardness in Reading. Remedies and Prevention. By John Duncan, O.B.E.. Harrap & Co. Ltd. 6/-

The fact that one third of the pupils who leave Secondary Modern and All Age Schools are backward in reading is an alarming one. In his short book, "Backwardness in Reading", John Duncan acknowledges that he has little that is new to tell us of the backward reader, his problems, prevention and cure. Nevertheless, one finds marshalled in this book, most of the useful views on this subject, presented with real sympathy for the sufferings of the reader, and the difficulties of the teacher, set in the whole environment, home as well as school.

He particularly stresses the following points:

(1) The teacher, who fails to realise that it is almost impossible to improve backwardness, if the child's home offers no range of experience, books or conversation, is setting himself a superhuman task. The education of the parent must proceed with that of the child.

(2) Reading must not be regarded as a subject both hateful and isolated, but must be linked with every activity and interest. Only those children who have learnt to use books during school will continue to read after they have left school.

(3) Failure in reading produces emotional disturbances, which are more serious than intellectual failure. Defeat, boredom, humiliation lead to asocial actions. When a new approach to reading has been tried and found successful, the child's whole character benefits.

Mr. Duncan sets out the pros and cons for Special Classes, and gives excellent advice on how to prevent backwardness and how to cope with it. There is a helpful list of books for pupil and teacher. But he warns us that the teacher who wishes to work with backward readers must be genuinely interested in the children as individuals, because the personal factor of the teacher is more important than any particular form of teaching or organisation.

I.M.S.

Prescription for Rebellion. Some Methods of Psychoanalysis Attacked by a Psychoanalyst. By Robert Lindner, Ph.D. Gollancz. 16/-

Though this book is doubtless thought-provoking, it contributes more from a negative point of view than from a positive one. Dr. Lindner writes in his prologue: "This volume is designed to sound an alarm". If the purpose then is to sound an alarm, the book does so quite effectively. Nevertheless, it does not give the reader a clear idea of what is to be done now that the alarm is sounded.

Dr. Lindner abhors adjustment. He regards it as "the single great myth of our time". To him it is a passive conforming resignation which produces the "flat features" of the "Mass Man".

He rebels against great contributors to his profession—Adler, Jung, Karen Horney, Harry Stack Sullivan and Otto Rank—because they all advocated adjustment. He also denounces psychiatric techniques like shock therapy and psycho-surgery. Regarding the latter effects of the former, he writes:

> "Something has indeed happened to the patient; he has been pulverized into submission, thrashed and smashed into cowed domesticity. If he can now meet the criteria of the 'shockiatrist' who has attended him—if he can be polite, keep himself tidy, respond with heartiness to his physician's cheery morning greetings, refrain from annoying people with his complaining and above all, make no noise, everything will be well. If not—quick, nurse, the little black box!"

What is condemned is not these techniques, as such, but their indiscriminate use to help bring about "adjustment".

In recent years there has been a number of books written which belong to the "what is wrong with psychoanalysis" school. It would appear that psychiatry and clinical psychology have reached a cross-road—that their disciples are becoming more critical of orthodox techniques. This is a healthy sign because out of such dissatisfaction, new and better techniques are bound to arise to supplant the old ones. Dr. Lindner is to be admired for his frank denouncement of a system he considers ineffective. He, himself, has considerable experience in analysis of "prisoners" and his book reflects a sympathetic understanding of rebels who are "maladjusted".

Nevertheless, the reader is left with a very hazy idea of the author's antidote to adjustment—that is, rebellion. Does this rebellion necessarily ensure that a human being will become a "person in his own right"? What constitutes a rebellion acceptable and beneficial to society? The remedy proposed in this book appears anarchistic and does little towards creating a sound science of psychiatry. Dr. Lindner himself, takes at their face value some highly controversial psychoanalytic theories. For instance, he cites the dogma of inborn hostility—that is, "children are characterized by violence, hostility, aggressiveness and smouldering resentment".

The reader cannot help but feel that this book, and others of its kind, would make a much greater contribution if they would embody more scientific investigation of psychiatric theories—those they reject and those they advocate. It is one thing to say that something is wrong (for instance, trying to make people adjusted), but it is another thing to demonstrate scientifically that it is wrong, and to investigate constructively another psychiatric method which is better.

V.F.

The Cardboard Giants. By Paul Hackett. Gollancz. 15/-.

This is a record of the experiences in a mental hospital of a patient suffering (apparently) from paranoid schizophrenia. As it is stated on the cover that the patient has recovered from his illness and that he has written the book under his own name, it is very difficult to make any comment from the clinical point of view without running the risk of doing harm. He himself has recorded and discussed his symptoms with considerable frankness but this does not absolve the physician from the duty of confining the expression of his opinions on the case to the patient himself or to his nearest relation. It is not right or proper that any such opinions should go forth for all to read.

The descriptions of the main delusion and of the occasional hallucinatory experiences are quite well done, as also the resulting modifications of labour—for example, the breaking of glasses and night wanderings, knife in hand. The interview with the medical staff wherein the patient exhibits the paranoid trend of his thought is particularly good.

From time to time a hint is given as to the background in childhood with an indication of a marked preference for one parent and an antipathy towards the other. Certain delinquent behaviour during the years before the full development of the illness is mentioned—typically without a word of regret.

The patient's wife is well described—so well, in fact that one feels a real sympathy for her, and indeed this portrait of a good and loyal woman face to face with a most difficult and painful situation, is most true to life.

The author's description of the hospital and life in the wards makes rather disturbing reading. It is unpleasant—at any rate to those with experience of mental hospitals in this country—to read that the male staff are described as "aides" and that they have apparently had no nursing training at all. Indeed one gets the impression that their main function is to quell outbreaks of violence which seem to be commonplace events instead of rarities as in the mental hospitals here.

The gradual development of some insight into his condition in the patient is well indicated though it is not clear, even towards the end of the book, as to how far this has gone.

Whether or not such books are suitable reading for the general public, still only too ready to think the worst of the mental hospital and its staff, is a matter about which opinions differ but from the practical point of view it is difficult to see any way in which they allay fears and prejudices and help towards a greater understanding of the treatment of mental illness.

F.B.

You and Your Aging Parents. By Edith M. Stern and Mabel Ross, M.D. New York: A. A. Wynn, Inc. $2.75

One of the authors of this book is well-known to mental health workers in the United States through her previous publications, including "Mental Illness; A Guide to the Family", "The Attendant's Guide" and "The Housemother's Guide". Her co-author is a psychiatrist and the Director of the Prince George County Mental Health Clinic, Maryland.

The advice given—although in some respects applicable more to conditions in America than to those in this country—is therefore based on sound principles and practical experience. To quote from the dust cover, the book "contains 100 real life stories covering every type of situation" within the scope of its special subject, i.e. the problems of married sons and daughters confronted with the necessity for planning a way of life for old parents—where they should live. Should they be offered a home with the family? If so, how will they fit in with the children? What financial arrangements should be made? What are the special characteristics and needs of old people which must be borne in mind? One situation is however left undealt with—that of the middle-aged unmarried daughter responsible for maintaining, single-handed, an aged father or mother—a situation which in this country is so common and which brings so many problems in its train.

But within its limits this is a book which is written so simply and covers so many details of the most homely and practical kind, that it should bring real help to those whose circumstances correspond with its subject matter. Indeed a possible criticism might be that its 21 chapters are so packed with sound advice that by the time the last page is reached the reader may feel that saturation point has been reached too.

A.L.H.

Social Service and Mental Health. An Essay on Psychiatric Social Workers. By Margaret Ashdown and S. Clement Brown. Routledge & Kegan Paul.

We are deferring a review of this important book until our next issue, in order that adequate space may be given to it.

Letters to the Editor

Dear Sir,

HALF-WAY HOUSES

As a mental health worker who has been watching the working out of the Mental Deficiency Acts for some years now, I would allow myself some honest criticism in the hope that it may be constructive.

I often wonder, allowing for the still serious lack of institutional accommodation in most areas, whether it is really necessary to make such provision for some of the high grade patients who are at present dealt with in this way. I find that many of these people—mostly girls between the ages of 15 and 20—are certified and institutionalised because their home background is bad, or even merely because their parents are too weak to be able to control them. Is it really fair to condemn these youngsters to a life of strict discipline and closed doors, simply because their natural urges are stronger than their ability to control them? It is untrue to say that most of them only stay in institutions for short periods; many stay there many years because *they have nowhere else to go.*

What then is the solution to this problem? I advocate "half-way Houses"—homes run by efficient women for young people who, although able to go out to work daily in local factories, hospitals, laundries and restaurants and to enjoy dances and other entertainments, need a measure of control and discipline such as the requirement for keeping regular hours, etc. Many border-line cases with I.Q.'s below normal, would also benefit from an environment of the kind without losing touch with everyday life.

By treating these youngsters as the children they mentally are, improvement would be certain and many untrained and undisciplined young people who would otherwise be a continuing cost to the State, would be turned into useful citizens to be eventually discharged from the provisions of the Mental Deficiency Acts altogether. Could not we try the experiment?

L. M. KOLL (Mrs.)

Hutton Rudby, Yarm, Yorks

Our correspondent is no doubt aware that Hostels connected with Institutions have long ago proved their value, and that the Agricultural Hostels run by the Central Association for Mental Welfare were an outstanding success. That Hostels should also be available for high-grade defectives who have not *been in Institutions, particularly for educationally subnormal school-leavers in need of a home, is becoming increasingly recognised, and the attention of the Ministry of Health has been drawn to it on several occasions.* ED.

CHILDREN IN HOSPITALS

You recently published an article by Mrs. H. Forres on "Emotional Dangers to Children in Hospitals," in which she describes very graphically the kind of incidents which can easily occur to children in Hospital, and expresses the feelings which such incidents are apt to arouse in observers from outside with a strong interest in children. It is hard not to be over-zealous under the impact of such feelings, but I think we have to remember that attack is not an effective means of persuasion, and that little can be done about the problems described without the willing co-operation of the nursing profession. It is relatively easy for Management Committees to impose changes in practice, such as frequent visiting by parents, but these are robbed of much of their virtue if nursing staff are disapproving and

resentful, and do not make the parents welcome. I think it is necessary to reach a very sympathetic insight into the predicament of childrens nurses before setting about to change their attitudes and behaviour.

The "hard type" looms very large in Mrs. Forres' article although, as she admits on page 61, "there are innumerable shades between the sympathetic and the unsympathetic, in fact there are infinitely more mixed than pure types." She also gives an instance (on page 60) of "hard" behaviour on the part of a nurse who was, in her own words, "far from heartless; in fact she was a good-natured person." Perhaps we should ask ourselves why even good-natured nurses often behave in the way described, and what is the nature of the frustration which may produce habitual hardness. Nurses of course are liable to their personal problems and frustrations like the rest of us, but they are commonly people who want to relieve sickness and suffering, because at heart they are particularly concerned about them. But in order to do this efficiently a great many natural feelings must be controlled; the nurse must learn not to react to the sight of blood or the impact of knife on flesh, not to flinch when she has to insert or remove stitches, or to change a dressing which has stuck. To realise the patient's pain or fear too acutely at such moments might make her incapable of doing what she has to do, and she therefore develops a self-protective habit of discounting or ignoring them.

Nurses and doctors have expressed anxiety that children's lives may be lost through infection brought by visitors; such investigation as has been done tends to indicate that this is a negligible factor, but the argument serves to remind us that the fear of losing lives is a constant strain on both nurses and doctors. But nurses, labouring under this strain, are far more constantly exposed than the doctors to the distress of child patients, distress which in many young children they can, with the best will in the world, do little to alleviate. This appears to be the reason for the irritation of the nurse described by Mrs. Forres: "Pauline *always* cries I want to go home . . . we have just got to let her cry." The nurse was annoyed at having her attention recalled to suffering which she knew by experience she was powerless to allay. I would say there was a good deal of pain in her irritation. It can often be observed in Children's Wards or Children's Hospitals (which are by no means immune from these problems) that the responsive children who are easily comforted get a good deal of attention; it is the children who cannot be comforted who tend to be ignored or even scolded, because their cries threaten to force the nurses to share their suffering, and the burden is too great to be borne. Visitors, observers, or short-stay adult patients can bear to perceive the child's pain because they are exposed to it for a limited period, and because, like Mrs. Forres, they are inclined to be optimistic about the possibility of relieving it by a little attention; also they have the nurses to be angry with. But nurses, who always have the sick child with them, and know how little they can do to comfort the more unhappy, tend to develop a protective habit of noticing only the happy ones, and are often honestly unaware of the unhappiness of the others. It may even be the more sensitive who scold the crying child, because they cannot ignore the cries, and there is no one to be angry with but themselves or the child.

Mrs. Forres demands that "the young nurse should be made to understand from within what a child in hospital is going through." It is important that reformers realise what a nurse will have to go through if she allows herself to be fully aware of the distress of sick children separated from their mothers, and that one cannot force this burden on her without giving very careful thought as to what can be done to make it bearable. It is indeed a very difficult problem, and probably not soluble without altering

many other features of Hospital life, such as the rigid discipline which prevails in so many. Theoretical teaching is certainly necessary, to help nurses understand that there is a real purpose in accepting all this suffering; but even so, it is doubtful whether the individual can bear it except with the support of a group in which personal relations are unusually good and which consciously accepts and shares the burden.

Yours faithfully,

E. E. IRVINE (Mrs.)
Psychiatric Social Worker.

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Recent Publications

REASON AND UNREASON IN PSYCHOLOGICAL MEDICINE. By E. B. Strauss, M.D., F.R.C.P. H. K. Lewis & Co. 8/6

THE CARDBOARD GIANTS. By Paul Hackett. Gollancz. 15/-

THE SCIENCE OF MIND AND BRAIN. By J. S. Wilkie, B.Sc., Ph.D. Hutchinson's University Library. 8/6

A MORE EXCELLENT WAY. By Leslie J. Tizzard, B.A., B.D., B.Litt. Independent Press, Memorial Hall, E.C.4. 7/6

FIRST CONTRIBUTIONS TO PSYCHO-ANALYSIS. By Sandor Ferenczi, M.D. Authorised Translation by Ernest Jones, M.D. Hogarth Press. 30/-

TRAUMA, GROWTH AND PERSONALITY. By Phyllis Greenacre, M.D., Cornell University, New York. Hogarth Press. 30/-

THE CASE AGAINST PSYCHO-ANALYSIS. By Andrew Salter. Medical Publications Ltd. 10/6

MEDICAL HYPNOSIS. By. Drs. Van Pelt, Gordon Ambrose and George Newbold. Gollancz. 13/6

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